DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALFANO

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 4/9/03

Relationship, if other than Claimant:

Company Name: N/A

Claimant's Social Security Number: 079-44-9148

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

P. 1

x x x TRANSMISSION RESULT REPORT (IMMEDIATE TX) (JUL. 24. 2003 11:24AM) x x x

FAX HEADER: CIGNA DALLAS

DATE	TIME	ADDRESS	MODE	TIME	PAGE	RESULT	PERSONAL NAME	FILE
JUL. 24.	11:23AM	NYPM	G3ES	0'51"	P. 4	OK		314

B :BATCH
M :MEMORY TX
S :STANDARD
X :PC

C :CONFIDENTIAL
L :SEND LATER
D :DETAIL
R :ROUTING

S :TRANSFER
B :FORWARDING
F :FINE
O :RECEPT. NOTICE REQ.

P :POLLING
E :ECM
J :REDUCTION
A :RECEPT. NOTICE

Facsimile Transmission Cover Sheet

2nd Request

CIGNA Group Insurance
Life - Accident - Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet)
212-746-8127	July 24, 2003	12:00 p.m.	

Name Dr. Keith Roach	Name Roberto Castellon
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5608
Address 505 E. 70 St. Ht. 450 New York, NY 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano
DOB: 1/14/58

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **Copies of your progress notes, including diagnostic test and lab results, from 1/1/01 to the present.**
- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **8/7/03** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Roberto Castellon
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

Disability Management Solutions™
Physical Abilities Assessment Form

CIGNA Group Insurance
Life - Accident - Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim in order to determine functional impairment.
Please document your objective findings *(check below)* and provide copies of supporting reports such as office notes/consultations/testing.
(Failure to provide the requested reports/data may result in delay in claim determination).

Claimant Name:	Date of Birth:
ICD-9 Diagnosis:	

Please check (✓) the boxes corresponding to the patient's level of physical functionality. Please substantiate your findings with medical documentation.

In an 8 hour workday, the patient can tolerate, with positional changes and rest breaks, the following activities for the specified durations:

ASSESSMENT OF PHYSICAL ABILITIES	CONTINUOUSLY (67% - 100%) (5.6+ hrs.)	FREQUENTLY (34% - 66%) (2.8 - 5 hrs.)	OCCASIONALLY (1% - 33%) (<2.8 hrs.)	NONE (0%) (0 hrs.)	CHECK (✓) IF SUPPORTED BY OBJECTIVE FINDINGS
Sitting:	☐	☐	☐	☐	☐
Standing:	☐	☐	☐	☐	☐
Walking:	☐	☐	☐	☐	☐
Climbing:	☐	☐	☐	☐	☐
Balancing:	☐	☐	☐	☐	☐
Kneeling:	☐	☐	☐	☐	☐
Crawling:	☐	☐	☐	☐	☐
Crouching:	☐	☐	☐	☐	☐
Stooping:	☐	☐	☐	☐	☐
Hearing:	☐	☐	☐	☐	☐
Reaching: Overhead	☐	☐	☐	☐	☐
Desk Level	☐	☐	☐	☐	☐
Below Wrist	☐	☐	☐	☐	☐
Seeing:	☐	☐	☐	☐	☐
Smelling/Tasting:	☐	☐	☐	☐	☐
Exposure to Extremes in Heat:	☐	☐	☐	☐	☐
Exposure to Extremes in Cold:	☐	☐	☐	☐	☐
Exposure to Odors/Fumes/Particles:	☐	☐	☐	☐	☐
Ability to Work Extended Hours/OT:	☐	☐	☐	☐	☐
Use of Lower Extremities for Foot Control:	☐	☐	☐	☐	☐
Exposure to Vibration:	☐	☐	☐	☐	☐
Exposure to Wet/Humid Conditions:	☐	☐	☐	☐	☐
Can Work Around Machinery:	☐	☐	☐	☐	☐
Fine Manipulation: Specify frequency and L or R					
Simple Grasp: Specify frequency and L or R					
Firm Grasp: Specify frequency and L or R					

(Continued on Reverse Side)

In the last column check (√) the box which corresponds to the patient's level of physical work function. Please substantiate your findings with medical documentation.

In an 8 hour workday, the patient can tolerate, with positional changes and meal breaks, the following:

PHYSICAL WORK LEVEL (Lift, Carry, Push, Pull)	CONTINUOUSLY Over 2/3 of the day (5 or more lbs/min.)	FREQUENTLY 1/3 to 2/3 of the day (Up to 4 lbs/min.)	OCCASIONALLY Up to 1/3 of the day (1 lb/35 min.)	APPROXIMATE ENERGY REQUIRED IN WORK METS*	MOST APPLICABLE IN YOUR OPINION (Check (√) One)
No Work	None	None	None	None	☐
Sedentary	Negligible (mostly sitting)	Negligible	10 lbs. (standiwalk occasionally)	1.5 - 2.1	☐
Light	Negligible	10 lbs. (standiwalk occasionally)	20 lbs.	2.2 - 3.5	☐
Medium	10 lbs.	10 - 25 lbs.	20 - 50 lbs.	3.6 - 5.0	☐
Heavy	10 - 20 lbs.	25 - 50 lbs.	50 - 100 lbs.	5.6 - 7.5	☐
Very Heavy	20 - 50 lbs.	50 - 100 lbs.	100+ lbs.	Over 7.5	☐

*One MET is equivalent to the amount of energy expended by a resting state, for example sitting in a chair and not moving. Activities can be calculated as multiples of the resting state. Therefore a 3 MET activity would mean the activity requires 3 times the amount of energy required to sit in a chair.

Additional Comments on Functionality:

Physician Name (Please Print):	Medical Specialty:
Address: (Street, City, State, Zip Code)	
Telephone Number:	Federal Tax ID #:
Physician Signature:	Date:

Thanks in advance for your prompt response to this request.

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALEANO

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

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Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 4/29/03

Relationship, if other than Claimant: N/A

Claimant's Social Security Number: 059-44-2948

Company Name:

PROHIBITION ON RE-DISCLOSURE

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04/25/2003 12:28 FAX CIGNA 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2123
CONNECTION TEL	912127468127
CONNECTION ID	
ST. TIME	04/25 12:27
USAGE T	00'45
PGS. SENT	2
RESULT	OK

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Total number of pages (including this sheet):
212-746-8127	April 25, 2003	2

To	From
Name: Dr. Keith Roach	Name: Maria Clarkin
Company:	Department: CIGNA Disability Management Solutions
Phone:	Phone: 1.800.376.0725 ext. 1519
Address:	Address: T1115 PO Box 2052 Tarrytown, NY 10591-9052

Comments:

RE: Claimant: Steven Alfano
DOB: 01/14/1958
Policy #: NYK 1972
Policy Name: Weil Medical College
Life Insurance Company of North America

I am writing to you concerning your above-named patient. At this time, I would appreciate your assistance in obtaining additional information needed in order to evaluate your patient's eligibility for long-term disability benefits.

Please provide us with all office notes, test results, and consultative reports from April 2002 through present. Enclosed is an authorization allowing you to release this information. This information can be faxed to me at 1-800-377-4286 if that is more convenient.

We realize that your time is valuable and will be [illegible]

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Total number of pages (including this sheet) :
212-746-8127	April 25, 2003	2

To	From
Name Dr. Keith Roach	Name Maria Clarkin
Company	Department CIGNA Disability Management Solutions
Phone	Phone 1.800.376.0725 ext. 1519
Address	Address T1115 PO Box 2052 Tarrytown, NY 10591-9052

Comments

RE: Claimant: Steven Alfano
DOB: 01/14/1958
Policy #: NYK 1972
Policy Name: Weil Medical College
Life Insurance Company of North America

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Please provide us with all office notes, test results, and consultative reports from April 2002 through present. Enclosed is an authorization allowing you to release this information. This information can be faxed to me at 1-800-377-4286 if that is more convenient.

We realize that your time is valuable and will be happy to honor a reasonable fee for completion of this request. Please include your Tax ID number with your billing invoice. We greatly appreciate your time and assistance. If you have any other information you feel would assist us in our evaluation of your patient's claim, please feel free to include it with the above reports. If you have any questions, please call me toll-free at 1-800-376-0725, ext. 1519.

[ ] Acknowledgment Requested

To Fax a reply, dial : 1-800-377-4286

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: *Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.*

Name: STEVEN ALFAND	Social Security No.: 099-44-9648
Address: 3800 WALDO AVE APT. 13-G BRONX, NY, 10463	Telephone No.: 718-884-2067

1. In your own words, tell us why you cannot work in your own or in any occupation.
CONSTANT BACK/LEG PAIN PREVENTS CONCENTRATION ON MENTAL TASKS CONDITION IS MADE WORSE BY SITTING, STANDING OR WALKING. SITTING ESPECIALLY PRODUCES PAIN AND NUMBNESS IN BUTTOCKS, LEGS AND FEET

2. What is primary physical and/or mental condition preventing you from working now?
SAME AS ANSWER TO #1 ABOVE PLUS I AM UNABLE TO STAND FOR ANY PERIOD OF TIME OR WALK DISTANCES DUE TO "FOOT DROP" I MUST LIE DOWN FREQUENTLY THROUGH THE DAY FOR 1-2 HOURS AT A TIME.

3. Can you drive? ☑ Yes ☐ No How far? 10-20 MINUTES

4. What time do you get up in the morning? BETWEEN 5-8 AM What time do you go to bed? BETWEEN 10-12 AM

5. Where do you live? ☑ Apartment ☐ House
How many floors in the apartment/house? 2ND Does it have an elevator? ☑ Yes ☐ No
Do you use any special equipment - ramps, handrails, wheelchair? ☐ Yes ☑ No
If yes, describe

6. Do you own a personal computer? ☑ Yes ☐ No
Is it connected to the Internet? ☑ Yes ☐ No
What computer programs or software can you use? NETSCAPE, WORD PERFECT
How often do you use the computer? 3-5 TIMES/WEEK

7. Check the things you do regularly:

Activity	Hours per day?	Days per week?
☐ Cook		
☐ Clean		
☐ Shop		
☐ Laundry		
☐ Yardwork		
☐ Gardening		
☐ Read		
☑ Watch TV	2-3 HRS	
☐ Other (school, attend religious services, volunteer work, etc.)		

What do you do for recreation? WATCH TV, LISTEN TO RADIO / MUSIC

8. Are there things you attend to with regard to your personal needs (grooming, dressing, etc.)?
I MUST TAKE LONG HOT BATHS DAILY TO EASE STIFFNESS. I DRESS IF I'M LEAVING THE HOUSE.

GB-0094286

9. Do you go for walks? ☐ Yes ☑ No How often? ____
How far do you walk? ____ For how long? ____

10. Do you engage in a regular exercise program? ☐ Yes ☑ No
Where (home, gym, etc.) ____
How often? ____
Describe your exercise program ____

11. Please circle the highest grade you completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 GED High School Diploma

College? 1 yr. 2 yrs. 3 yrs. 4 yrs. BA/BS Degree Masters Degree Other

Type of degree? (Business, History, Social Sciences, etc.) BBA
Date Received 2/91
List any professional/educational certificates, licenses, etc. awarded NONE
List any vocational programs you have attended/completed NONE
In the last 3 years, what type of certificates or licenses have you received? NONE

12. Are you taking any professional/educational/vocational classes now? ☐ Yes ☑ No
Please list them ____

13. Are you working? ☐ Yes ☑ No
If so, please list how many hours per day you work, and the name of your employer. ____

Employment History

1. Job Title: WAGE & SALARY MGR.	Employed date: From: 2/91 Through: 12/00
Major Duties: DEVELOP AND ADMINISTER COMPENSATION SYSTEMS, NEGOTIATE ENABLES	Minor Duties: ADMINISTER PERFORMANCE EVALUATION SYSTEMS, APPROVE JOB DESCRIPTIONS
Tools/Equipment used: COMPUTER, CALCULATOR	Machinery/Computers used: PC, MAINFRAME
2. Job Title: ASST DIR, HUMAN RESOURCES	Employed date: From: 3/90 Through: 1/91
Major Duties: ADMINISTERED COMPENSATION AND EMPLOYMENT FUNCTIONS	Minor Duties: ADMINISTER EMPLOYEE IMMIGRATION, HOUSING AND ORIENTATION PROGRAMS
Tools/Equipment used: CALCULATOR	Machinery/Computers used: PC
3. Job Title: WAGE AND SALARY ANALYST/MGR	Employed date: From: 8/87 Through: 2/90
Major Duties: ADMINISTRATION OF WAGES AND SALARIES	Minor Duties: LABOR RELATIONS
Tools/Equipment used: CALCULATOR	Machinery/Computers used: PC

14. Have you ever owned or operated your own business? ☐ Yes ☑ No
Do you own, operate or have ownership interest in a business now? ☐ Yes ☑ No
Business Name ____
Address ____
City ____
Telephone Number (____) ____
Date business began ____
Describe the business ____

15. Are you married? ☑ Yes ☐ No DOB: 5/25/62
If yes, please provide: Spouse's Name: EVA ALEANO
Spouse's SSN: 160-65-9657

Do you have any children under age 18? ☑ Yes ☐ No
Please list their names and dates of birth in order:
ANDREA ALEANO 10/1/92
MICHAEL ALEANO 5/18/95

Do you have any handicapped children over 18? ☐ Yes ☑ No

16. List any prescription medications you take: Use other side if you need more space.

Medication	Dose	Frequency	Medication	Dose	Frequency
VIOXX	50 MG	1/DAY	PREVACID	30 mg	1/DAY
VICODIN	5 MG	1-2 EVERY 4 HRS	NEURONTIN	150 mg	2/DAY
ZESTRIL	2.5 MG	1/DAY			

17. List any doctor(s) you see regularly. Use the other side if you need more room.

Doctor's Name/Specialty: KEITH ROACH / INTERNAL MEDICINE	Doctor's Name/Specialty: MICHAEL ALEXIADES / ORTHOPEDIC SURGERY
Address: 505 E 70 ST HT 450 NY NY 10021	Address: 159 E 74 ST NY NY 10021
Telephone #: 212-746-2879 Fax #: 212-746-9127	Telephone #: 212-734-1298 Fax #: 212-439-6855
Frequency of visits: 3-6 mos Date of last visit: 4/7/03	Frequency of visits: 3-6 mos Date of last visit: 4/16/03
Doctor's Name/Specialty:	Doctor's Name/Specialty:
Address:	Address:
Telephone #: Fax #:	Telephone #: Fax #:
Frequency of visits: Date of last visit:	Frequency of visits: Date of last visit:

18. Are you right handed or left handed? ☐ Right ☑ Left
What is your height? 6'3"
What is your weight? 290
What is your date of birth? 1/14/58

19. Are you a veteran? ☐ Yes ☑ No
If yes, have you applied for VA benefits for this disability? ☐ Yes ☐ No
Please attach a copy of your VA disability award.

20. What other types of income/money/compensation/benefits are you receiving or eligible to receive?

		Source & Amount/Frequency	Date Began	Date Paid Through
☐ Yes	☑ No	Salary Continuance		
☐ Yes	☑ No	State Disability Benefits		
☐ Yes	☑ No	Group Disability Benefits	except Aetna policy	
☐ Yes	☑ No	Workers' Compensation		
☐ Yes	☑ No	Pension Benefits		
☐ Yes	☑ No	No-Fault Auto Disability Insurance		
☑ Yes	☐ No	Any Other Disability Income	Social Security DIB $1,591/mo.	1/2002 Present

I certify that the information in this document is true and correct.

Signature [signature] Date 4/20/03

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALEANO

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

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Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 4/29/03

Relationship, if other than Claimant: N/A

Claimant's Social Security Number: 059-44-2948

Company Name:

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient

EE: ALFANO, STEVEN	SSN: 099-44-9648	DOI: 06/06/2000	ER: WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY(DIS)	ID: 854973378660580
WCC:	LTD:	STD:	ICMS:	Other:

View the Details for an Incident Note

Add a New Incident Note

Date/Time Created	Subject	Detail	Author	Source
04/16/2003 09:07:15 AM Edit	Medical/Disability Management	Narrative	CLARKIN, MARIA	ICARE

ICARE Note Text

Medical was reviewed by NCM. Med. does not match w/prior treatment. Office notes from Dr. Alexiades for 2002 show problems w/Shoulder and hip.
Called AP office and confirmed that the medial is correct. Will send requst for DQ to cx for current ADL's. Will also send requst for medical if treating w/new AP.

Add a New Incident Note

Maria Clarkin
Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life · Accident · Disability

Routing T1113
PO Box 2052
Tarrytown, NY 10591-9052
Telephone 1.800.376.0725 ext. 1519
Facsimile 1.800.377.4286

April 16, 2003

STEVEN ALFANO
3800 WALDO AVE APT 13-G
BRONX NY 10463

Claimant:	Steven Alfano
Policy Number:	NYK 1972
Policyholder Name:	Cornell University
Underwriting Company:	Life Insurance Company of North America

Dear Mr. Alfano,

We are writing to you concerning your disability benefits. In order to continue your benefits, we need current information from you.

Please complete the enclosed questionnaire and return it in the envelope we have provided for your convenience.

If you have any questions, please call me toll-free at 1.800.376.0725 ext. 1519, Monday through Friday from 8 a.m. to 4:30 p.m. Eastern Time. We also offer a toll-free line for the hearing impaired at 1.800.336.2485. Thank you for your attention to this matter.

Sincerely,

Maria Clarkin

MC/mc

EE: ALFANO, STEVEN	SSN: 099-44-9648	DOI: 06/06/2000	ER: WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY(DIS)	ID: 854973378660580
WCC:	LTD:	STD:	ICMS:	Other:

View the Details for an Incident Note

(first record) Add a New Incident Note

Date/Time Created	Subject	Detail	Author	Source
02/24/2003 03:55:35 PM Edit	Medical/Disability Management	Narrative	CLARKIN, MARIA	ICARE

ICARE Note Text

Medical update rec. will discuss w/NCM.

(first record) Add a New Incident Note

This CM note does not match what is it??
I'm Velma & Dr. Alexiades office. It is correct what we Doris treated for shoulder. MVP
Maria

Maria Clarkin
Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life · Accident · Disability

Routing T1115
PO Box 2032
Tarrytown, NY 10591-9052
Telephone 1.800.376.0725
ext. 1519
Facsimile 860.687.9494

February 10, 2003

MICHAEL ALEXIADES MC PC
159 EAST 74TH ST
NEW YORK NY 10021

Claimant:	Steven Alfano
DOB:	01/14/1958
Policy Number:	NYK 1972
Policyholder:	Weill Mecical College
Underwriting Company:	Life Insurance Company of North America

Dear Dr. Alexiades,

We are writing to you concerning your above-named patient. At this time, we would appreciate your assistance in obtaining additional information needed in order to evaluate your patient's eligibility for ongoing disability benefits.

Please provide us with all office notes, test results, and consultative reports from August 1, 2002 through present. Enclosed is an authorization allowing you to release this information. This information can be faxed to us at 1-800-377-4286 if that is more convenient.

We realize that your time is valuable and will be happy to honor a reasonable fee for completion of this request. Please include your Tax ID number with your billing invoice. We greatly appreciate your time and assistance. If you have any other information you feel would assist us in our evaluation of your patient's claim, please feel free to include it with the above reports. If you have any questions, please call me toll-free at 1.800.376.0725 ext. 1519.

Sincerely,

Maria Clarkin

MICHAEL M. ALEXIADES, M.D., P.C.
159 EAST 74TH
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1288

04/22/02 Mr. Steven Alfano returns with increasing pain in his left shoulder which previous MRI showed tendonopathy. In addition he is having some right anterolateral hip pain. Right shoulder is doing relatively well. We discussed options an he will consider a left shoulder arthroscopic procedure. In the interim we will get films of the right hip.

07/08/02 Mr. Steven Alfano returns post shoulder arthroscopy. Range of motion and strength are good. Plan: Continue rehab on his own. The patient will return for follow up in six weeks. At that point we will discuss his right hip and possible arthroscopy. He saw Dr. Springfield who has cleared the hip from an oncology point of view.

09/23/02 Mr. Steven Alfano returns post shoulder arthroscopy. Occasional AC joint discomfort but strength and range of motion are excellent. Plan: Continue exercise regimen. The patient will return for follow up in the future prn.
He wished to discuss hip arthroscopy. The material risks, benefits and alternatives were discussed with the patient who understands and will decide.

Maria Clarkin
Case Manager
Disability Management Solutions

CIGNA Group Insurance
Life · Accident · Disability

Revised Letter

April 10, 2003

STEVEN ALFANO
3800 WALDO AVE APT 13-G
BRONX NY 10463

Claimant:	Steven Alfano
Policy Number:	NYK 1972
Policyholder Name:	Weill Medical Group
Underwriting Company:	Life Insurance Company of North America

Dear Mr. Alfano,

As you know we have been reviewing your claim.

Based on our review of your file, your claim has been re-opened and benefits approved to date. You will be receiving a check under separate cover for the period of December 3, 2002 through February 2, 2003, in the amount of $48,806.88.

To qualify for benefits under your Long Term Disability (LTD) contract, you must be unable to engage in the essential duties of your regular occupation to qualify for benefits, subject to any other benefit limitations stated in your contract. We will be requesting periodic updates on the status of your disability and we reserve the right to have you examined by a physician of our choice.

Please note that Monthly Benefits are payable only while you are under the care of a licensed physician.

If you have any questions regarding your claim, please feel free to contact me at any time.

Sincerely,

Maria Clarkin

CC: Clare McDonough

CORNELL
UNIVERSITY

Joan and Sanford I. Weill
Medical College

Department of Human Resources
Benefits Office
445 East 69th Street, Room 220
New York, NY 10021

March 27, 2003

Ms. Maria Clarkin
Case Manager
CIGNA Group Insurance
Routing 1115
P.O. Box 2052
Tarrytown, NY 10591-9052

Re: NYK 1972
Steven Alfano – Long Term Disability Plan Benefit Recipient

Dear Ms. Clarkin:

I wish to point out an error contained in the letter you sent to Mr. Steven Alfano on January 24, 2003. As you may recall, our contract with CIGNA is occupation specific; therefore, the statement contained in the letter referenced – "you must be unable to engage in the essential duties of any occupation to qualify for benefits" is incorrect.

Please issue Mr. Alfano a revised letter with correct reference to occupation specific. I appreciate your assistance and please call me at (212) 746-1035 if you need any additional information.

Sincerely,

Clare McDonough
Associate Director – Benefits & Administration

Cc: S. Alfano

Maria Clarkin
Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life - Accident - Disability

Routing T1115
PO Box 2052
Tarrytown, NY 10591-9052
Telephone 1.800.376.0725
ext. 1519
Facsimile 860.687.9494

February 10, 2003

MICHAEL ALEXIADES MC PC
159 EAST 74TH ST
NEW YORK NY 10021

Claimant:	Steven Alfano
DOB:	03/34/1958
Policy Number:	NYK 1972
Policyholder:	Weill Medical College
Underwriting Company:	Life Insurance Company of North America

Dear Dr. Alexiades,

We are writing to you concerning your above-named patient. At this time, we would appreciate your assistance in obtaining additional information needed in order to evaluate your patient's eligibility for ongoing disability benefits.

Please provide us with all office notes, test results, and consultative reports from August 1, 2002 through present. Enclosed is an authorization allowing you to release this information. This information can be faxed to us at 1-800-377-4286 if that is more convenient.

We realize that your time is valuable and will be happy to honor a reasonable fee for completion of this request. Please include your Tax ID number with your billing invoice. We greatly appreciate your time and assistance. If you have any other information you feel would assist us in our evaluation of your patient's claim, please feel free to include it with the above reports. If you have any questions, please call me toll-free at 1.800.376.0725 ext. 1519.

Sincerely,

Maria Clarkin

Disclosure Authorization

CIGNA Group Insurance
Life • Accident • Disability

CIGNA

Insured's Name (Please Print) ALFANO, STEVEN

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, or pharmacy to give the Insurance Company named below (Company) or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: I) cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions of advice of my physical or mental condition of information concerning me which may be needed to determine policy claim benefits with respect to Insured. This may also include (but is not limited to) information concerning: mental illness, psychiatric, alcohol or drug use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome.)

I AUTHORIZE: any financial institution, accountant, tax preparer, insurer or reinsurance consumer reporting agency, insurance support organization, Insured's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim history, work history, and work related activities.

I AUTHORIZE: the Company to contact my employer to investigate and evaluate return to work opportunities. I understand that in doing so the Company may release medical information and other information related to my physical limitations to my employer.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used by the Company to determine eligibility for claim benefits and any amounts payable with respect to the Claimant. This authorization shall apply to all records, information and events that occur over the duration of the claim. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I may revoke this authorization at any time for information not then obtained by writing to the Company. The information obtained will not be released to anyone else EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim; e) for audit or statistical purposes; f) as may be required by law; g) as I may further authorize.

Claimant's Signature _____ Date: 6/22/02
(Claimant or Claimant's authorized representative)

Relationship, if other than Claimant _____

Claimant's Social Security Number 099-44-9648

Insurance Company Name Life Insurance Company of North America

612280

EE: ALFANO, STEVEN	SSN: 099-44-9648	DOI: 06/06/2000	ER: WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY(DIS)	ID: 8549733786660580
WCC:	LTD:	STD:	ICMS:	Other:

View the Details for an Incident Note

Add a New Incident Note (last record)

Date/Time Created	Subject	Detail	Author	Source
01/27/2003 02:24:24 PM Edit	Medical/Disability Management	Narrative	SCOTTON, LISA	ICARE

ICARE Note Text

Occupation: Wage and Salary Mgr. (sedentary)
Incur Date: 6/6/00 BSD: 12/3/00
Policy # NYK 1972 A/O date: 12/3/00
Date of Referral: 1/27/03

Referral Questions: Claim reopen on appeal. Per medical ex found to have severe multilevel spinal stenosis & nerve root impingement. Please review medical and advise if ex may rtw in the future w/tx or would a referral to SAM be reasonable.

FILE DISCUSSED @ WALK-UP.
MEDICAL AT HAND SUPPORTS SYMPTOMATIC MULTILEVEL SPINAL STENOSIS AND NERVE ROOT IMPINGEMENT SUPPORTED BY CLINICAL EXAM FINDINGS AND PEER REVIEW. CLMNT HAS NOT RESPONDED TO CONSERVATIVE MANANGEMENT.
12/10/02 PEER REVIEW INDICATES SEVERAL APs HAVE RECOMMENDED SURGERY:
* 7/00 DR. ALEXIADES REFERS TO SPINE SURGEON FOR POSSIBLE FUSION; 1/01 SURGERY STILL RECOMMENDED.
* 8/00 DR. SNOW INDICATES PLAN IS FOR L5-S1 LUMBAR LAMINECTOMY @ L5 BILATERALLY W/ POSSIBLE DISCKECTOMY @ L5-S1 ON THE LEFT.
* 1/01 DR. SCHIFF NOTES CLMNT NEEDS SURGERY FOR L5-S1 STENOSIS/SPONDYLOSIS
* 2/01 DR. FARMER (HOSPITAL FOR SPECIAL SURGERY) NOTES CLMNT MAY REQUIRE A LUMBAR FUSION IF NO IMPROVEMENT W/ CONSERVATIVE CARE. HOWEVER, AS OF 2/02,CLMNT REMAINS IN CONSERVATIVE TX OF PT, ESI & MEDS. IT IS UNCLEAR IF CLMNT HAS ELECTED TO PURSUE SURGICAL INTERVENTION - MOST RECENT MEDICAL @ HAND IS A 7/12/02 NARRATIVE FROM DR. ALEXIADES INDICATING THAT SURGERY HAS BEEN DISCUSSED.
AT THIS TIME, WOULD SUGGEST OBTAINING UPDATE FROM CLMNT AND DR. ALEXIADES AS SIX MONTHS HAVE PASSED SINCE THIS NARRATIVE AND CURRENT STATUS IS UNCLEAR.

January 22, 2003

Maria Clarkin
CIGNA
P.O. Box 2052
Tarrytown, NY 10591-9052

Dear Ms. Clarkin,

Re: Steven Alfano, Soc.Sec. #: 099-44-9648

Enclosed per your request, please find copies the Social Security Notices of Award for myself and my family.

Steven Alfano
3800 Waldo Ave., Apt. 13-G
Bronx, NY 10463

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: October 22, 2002
Claim Number: 099-44-9648HC1

STEVEN ALFANO FOR
MICHAEL JAMES ALFANO
3800 WALDO AVEUE
APT 13G
BRONX, NY 10463-2369

MICHAEL J ALFANO is entitled to monthly child's benefits beginning December 2000.

We have chosen you to be his representative payee. Therefore, you will receive his checks and use the money for his needs.

What We Will Pay And When

- You will receive $8,393.00 around October 28, 2002.
- This is the money MICHAEL is due for December 2000 through September 2002.
- MICHAEL J ALFANO's next payment of $387.00, which is for October 2002, will be received on or about the third Wednesday of November 2002.
- After that you will receive $387.00 on or about the third Wednesday of each month.

The day we make payments on this record is based on STEVEN A ALFANO's date of birth.

Your Benefits

We raised his monthly benefit amount beginning December 2001 because the cost of living increased.

We changed his monthly benefit amount beginning January 2001 because we raised Mr. ALFANO's benefit.

Enclosure(s):
Pub 05-10076
Pub 05-10077
Pub 05-10058

C

See Next Page

Work And Earnings Affect Payments

The monthly earnings test applies only to 1 year. That year is the first year a beneficiary has a non-work month after entitlement to Social Security benefits. Our records show that MICHAEL had or will have at least one non-work month in 2000. If he ever goes to work, we will pay benefits for each year based on his work and earnings for that year.

Health Insurance For Children

If this notice is for a child under age 19 who is not covered by health insurance, there is a Children's Health Insurance Program that may help. To find out more, you can look on the Internet at www.insurekidsnow.gov or call, toll free, 1-877-KIDS-NOW (1-877-543-7669). The number connects you to your state program.

Other Social Security Benefits

The benefit described in this letter is the only one he can receive from Social Security. If you think that he might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

MICHAEL's benefits are based on the information you gave us. If this information changes, it could affect his benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "When You Get Social Security or Survivors Benefits...What You Need to Know". It tells you what must be reported and how to report. Please be sure to read that part of the pamphlet which explains how work could change payments.

As a representative payee, you have additional responsibilities. They are discussed in the enclosed pamphlet, "A Guide for Representative Payees."

Do You Disagree With The Decision?

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide MICHAEL's case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to him.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.

- You have to ask for an appeal in writing. We will ask you to sign a Form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

If You Want Help With Your Appeal

You can have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due benefits to pay toward the fee.

If You Have Any Questions

We invite you to visit our website at www.ssa.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-212-923-7960. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
CORNER 182 ST
4292 BROADWAY
NEW YORK, NY 10033

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Jo Anne B. Barnhart
Commissioner
of Social Security

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: October 22, 2002
Claim Number: 099-44-9648HC2

STEVEN ALFANO FOR
ANDREA ROSE ALFANO
3800 WALDO AVEUE
APT 13G
BRONX, NY 10463-2169

ANDREA R ALFANO is entitled to monthly child's benefits beginning December 2000.

We have chosen you to be her representative payee. Therefore, you will receive her checks and use the money for her needs.

What We Will Pay And When

- You will receive $8,393.00 around October 28, 2002.
- This is the money ANDREA is due for December 2000 through September 2002.
- ANDREA R ALFANO's next payment of $387.00, which is for October 2002, will be received on or about the third Wednesday of November 2002.
- After that you will receive $387.00 on or about the third Wednesday of each month.

The day we make payments on this record is based on STEVEN A ALFANO's date of birth.

Your Benefits

We raised her monthly benefit amount beginning December 2001 because the cost of living increased.

We changed her monthly benefit amount beginning January 2001 because we raised Mr. ALFANO's benefit.

Enclosure(s):
Pub 05-10076
Pub 05-10077
Pub 05-10058

C

See Next Page

Work And Earnings Affect Payments

The monthly earnings test applies only to 1 year. That year is the first year a beneficiary has a non-work month after entitlement to Social Security benefits. Our records show that ANDREA had or will have at least one non-work month in 2000. If she ever goes to work, we will pay benefits for each year based on her work and earnings for that year.

Health Insurance For Children

If this notice is for a child under age 19 who is not covered by health insurance, there is a Children's Health Insurance Program that may help. To find out more, you can look on the Internet at www.insurekidsnow.gov or call, toll free, 1-877-KIDS-NOW (1-877-543-7669). The number connects you to your state program.

Other Social Security Benefits

The benefit described in this letter is the only one she can receive from Social Security. If you think that she might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

ANDREA's benefits are based on the information you gave us. If this information changes, it could affect her benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "When You Get Social Security or Survivors Benefits...What You Need to Know". It tells you what must be reported and how to report. Please be sure to read that part of the pamphlet which explains how work could change payments.

As a representative payee, you have additional responsibilities. They are discussed in the enclosed pamphlet, "A Guide for Representative Payees."

Do You Disagree With The Decision?

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide ANDREA's case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to her.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.

- You have to ask for an appeal in writing. We will ask you to sign a Form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

If You Want Help With Your Appeal

You can have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due benefits to pay toward the fee.

If You Have Any Questions

We invite you to visit our website at www.ssa.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-212-923-7960. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
CORNER 182 ST
4292 BROADWAY
NEW YORK, NY 10033

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Jo Anne B. Barnhart

Jo Anne B. Barnhart
Commissioner
of Social Security

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: October 14, 2002
Claim Number: 099-44-9648HA

STEVEN A ALFANO
3800 WALDO AVE
APT 13G
BRONX, NY 10463-2169

You are entitled to monthly disability benefits beginning December 2000.

The Date You Became Disabled

We found that you became disabled under our rules on June 5, 2000.

However, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is December 2000.

What We Will Pay And When

- You will receive $1,550.00 for October 2002 around November 20, 2002.
- After that you will receive $1,550.00 on or about the third Wednesday of each month.
- Later in this letter, we will show you how we figured these amounts.

The day we make payments on this record is based on your date of birth.

Enclosure(s):
Pub 05-10153
Pub 05-10058

C

See Next Page

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive(s) may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
December 2000	$1,507.40	Entitlement began
January 2001	$1,510.80	Credit for additional earnings
December 2001	$1,550.00	Cost-of-living adjustment

Other Government Payments Affect Benefits

We are holding your Social Security benefits for December 2000 through September 2002. We may have to reduce these benefits if you received Supplemental Security Income (SSI) for this period. We will not reduce your past-due benefits if you did not get SSI benefits for those months.

However, we will withhold part of any past-due benefits to pay your lawyer. Later in this letter, we will tell you more about the money we are withholding to pay your lawyer. When we decide how much you are due for this period, we will send you another letter.

Information About Medicare

You are entitled to medicare hospital and medical insurance beginning December 2002.

We will send you a Medicare card. You should take this card with you when you need medical care. If you need medical care before receiving the card and your coverage has already begun, use this letter as proof that you are covered by Medicare.

Information About Lawyer's Fees

We have approved the fee agreement between you and your lawyer.

Your past-due benefits are $33,617.00 for December 2000 through September 2002. Under the fee agreement, the lawyer cannot charge you more than $4,000.00 for his or her work. The amount of the fee does not include any out-of-pocket expenses (for example, costs to get copies of doctors' or hospitals' reports). This is a matter between you and the lawyer.

If we approve your claim for SSI, the lawyer may be able to charge an additional amount for his or her work. We will send you another letter about SSI telling you the additional amount of the fee, if any, he or she can charge.

How To Ask Us To Review The Determination On The Fee Amount

You, the lawyer or the person who decided your case can ask us to review the amount of the fee we say the lawyer can charge.

If you think the amount of the fee is too high, write us within 15 days from the day you get this letter. Tell us that you disagree with the amount of the fee and give your reasons. Send your request to this address:

Social Security Administration
Office of Hearings and Appeals
Attorney Fee Branch
5107 Leesburg Pike
Falls Church, Virginia 22041-3255

The lawyer also has 15 days to write us if he or she thinks the amount of the fee is too low.

If we do not hear from you or the lawyer, we will assume you both agree with the amount of the fee shown.

Information About Past-Due Benefits Withheld To Pay A Lawyer

Because of the law, we usually withhold 25 percent of the total past-due benefits to pay an approved lawyer's fee. We withheld $8,404.25 from your past-due benefits to pay the lawyer.

We are paying the lawyer from the benefits we withheld. Therefore, we must collect from the lawyer a service charge of 6.3 percent of the fee amount we pay. We will subtract the service charge from the amount payable to the lawyer. This means that we subtract $252.00 from the $4,000.00 we are paying toward the lawyer's fee, and send him or her $3,748.00.

The lawyer cannot ask you to pay for the service charge. If the lawyer disagrees with the amount of the service charge, he or she must write to the address shown at the top of this letter. The lawyer must tell us why he or she disagrees within 15 days from the day he or she gets this letter.

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "When You Get Social Security Disability Benefits...What You Need To Know." It will tell you what must be reported and how to report. Please be sure to read the parts of the pamphlet which explain what to do if you go to work or if your health improves.

A state or other public or private vocational rehabilitation provider may contact you to talk about their services. The rehabilitation provider may offer you counseling, training, and other services that may help you go to work. To keep getting disability benefits, you have to accept the services offered unless we decide you have a good reason for not accepting.

You do not have to wait to be contacted about vocational rehabilitation services. You can contact the nearest state vocational rehabilitation office directly and let them know that you are interested in receiving services.

If you go to work, special rules can allow us to continue your cash payments and health insurance coverage. For more information about how work and earnings may affect disability benefits, you may call or visit any Social Security office. You may wish to ask for any of the following publications:

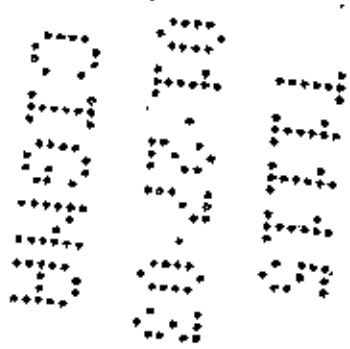
- Social Security - Working While Disabled...How We Can Help (SSA Publication No. 05-10095).
- Social Security - If You Are Blind--How We Can Help (SSA Publication No. 05-10052).
- How Social Security Can Help With Vocational Rehabilitation (SSA Publication No. 05-10050).

Other Information

We are sending a copy of this notice to KENNETH SCHEER and ADAM COHEN.

Do You Disagree With The Decision?

This action supersedes our previous determination and is in accordance with the decision on your hearing request. You have already been notified of your appeal rights regarding the decision made on your hearing request and what you must do to have that decision reexamined. If you want this reconsideration, you may request it through any Social Security office. If additional evidence is available, you should submit it with your request. We will review the case and consider any new facts you have. A person who did not make the first decision will decide your case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to you.



- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a Form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

Things To Remember For The Future

Doctors and other trained staff decided that you are disabled under our rules. But, this decision must be reviewed at least once every 3 years. We will send you a letter before we start the review. Based on that review, your benefits will continue if you are still disabled, but will end if you are no longer disabled.

If You Have Any Questions

We invite you to visit our website at www.ssa.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-212-928-7960. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
CORNER 182 ST
4292 BROADWAY
NEW YORK, NY 10033

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Jo Anne B. Barnhart
Commissioner
of Social Security

PAYMENT SUMMARY

Your Regular Monthly Payment

Here is how we figured your regular monthly payment effective October 2002:

You are entitled to a monthly benefit of	$ 1,550.00
This equals the amount of your regular monthly payment	$ 1,550.00

Maria Clarkin
Case Manager
Disability Management Solutions

January 24, 2003

CIGNA Group Insurance
Life · Accident · Disability

Routing 1115
P.O. Box 2052
Tarrytown NY 10591-9052
Telephone 1(800)376-0725
Facsimile 1(800)377-4286

STEVEN ALFANO
3800 WALDO AVE APT 13-G
BRONX NY 10463

Claimant:	Steven Alfano
Policy Number:	NLK 1972
Policyholder Name:	Weill Medical Group
Underwriting Company:	Life Insurance Company of North America

Dear Mr. Alfano,

As you know we have been reviewing your claim.

Based on our review of your file, your claim has been re-opened and benefits approved to date. You will be receiving a check under separate cover for the period of December 3, 2000 through February 2, 2003, in the amount of $48,806.88. Please see the enclosed calculation worksheets.

To qualify for benefits under your Long Term Disability (LTD) contract, you must be unable to engage in the essential duties of any occupation to qualify for benefits, subject to any other benefit limitations stated in your contract. We will be requesting periodic updates on the status of your disability and we reserve the right to have you examined by a physician of our choice.

Please note that Monthly Benefits are payable only while you are under the care of a licensed physician.

If you have any questions regarding your claim, please feel free to contact me at any time.

Sincerely,

Maria Clarkin
MC/mc

MANDATORY WORKSHEET FOR REOPENING A CLAIM

Claimant Name: Steven Alfano

SS# 099-44-9648

Policy # NYE 1972

Net Benefit: $1888.32

Date Closed: 7/10/2002

CM/Office: Mary Ryan

Date Reopened: 01/22/2003

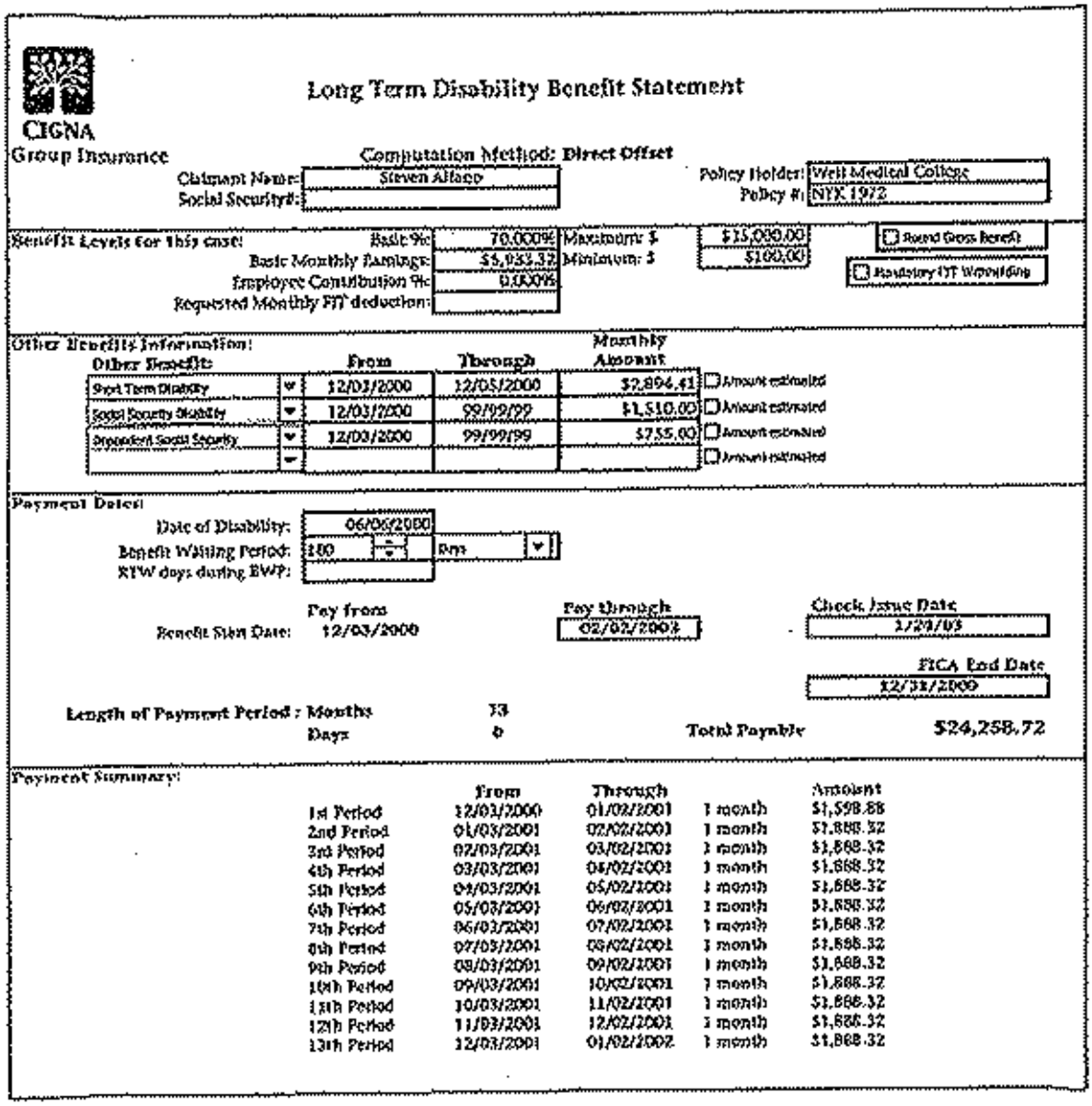
CM: Marie Clarkin

Reason for Denial: Cx did not satisfy the 180 day waiting period. Cx released to rtw w/in the waiting period. No R&L's noted that would prevent him from working his sedentary job.

Rationale for Reopen: Claim decision overturned by the appeal's team. Medical records indicate cx has ongoing dx of sever multilevel spinal stenosis and nerve root impingement which prevents him from performing his full time occ from incur date forward.

Action Plan/File Direction: Will have NCM review file for R&L's and possible refer to SAM.

Team Leader/Sr. CM Signature and Date:



CIGNA
Group Insurance

Long Term Disability Benefit Statement

Computation Method: Direct Offset

Claimant Name: Steven Allaco
Social Security#:

Policy Holder: Weill Medical College
Policy #: NYX 1972

Benefit Levels for this case:

Basic %:	70.0000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,953.32	Minimum: $	$100.00
Employee Contribution %:	0.0000%		
Requested Monthly FIT deduction:			

☐ Round Gross Benefit
☐ Mandatory FIT Withholding

Other Benefits Information:

Other Benefits:	From	Through	Monthly Amount	
Short Term Disability	12/03/2000	12/05/2000	$2,894.41	☐ Amount estimated
Social Security Disability	12/03/2000	99/99/99	$1,510.00	☐ Amount estimated
Dependent Social Security	12/03/2000	99/99/99	$755.00	☐ Amount estimated
				☐ Amount estimated

Payment Dates:

Date of Disability: 06/06/2000
Benefit Waiting Period: 180 Days
RTW days during EWP:

Benefit Start Date: Pay from 12/03/2000
Pay through 02/02/2003
Check Issue Date 1/29/03
FICA End Date 12/31/2000

Length of Payment Period : Months 13
Days 0
Total Payable $24,258.72

Payment Summary:

	From	Through		Amount
1st Period	12/03/2000	01/02/2001	1 month	$1,598.88
2nd Period	01/03/2001	02/02/2001	1 month	$1,868.32
3rd Period	02/03/2001	03/02/2001	1 month	$1,868.32
4th Period	03/03/2001	04/02/2001	1 month	$1,868.32
5th Period	04/03/2001	05/02/2001	1 month	$1,868.32
6th Period	05/03/2001	06/02/2001	1 month	$1,868.32
7th Period	06/03/2001	07/02/2001	1 month	$1,868.32
8th Period	07/03/2001	08/02/2001	1 month	$1,868.32
9th Period	08/03/2001	09/02/2001	1 month	$1,868.32
10th Period	09/03/2001	10/02/2001	1 month	$1,868.32
11th Period	10/03/2001	11/02/2001	1 month	$1,868.32
12th Period	11/03/2001	12/02/2001	1 month	$1,868.32
13th Period	12/03/2001	01/02/2002	1 month	$1,868.32

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weill Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 12/03/2000 Through: 01/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Short Term Disability	$280.44	Prorated for 3 days this period
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$755.00	Calculated for entire period of 1 month
Net Benefit:	$1,598.88	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,598.88

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weil Medical College
Social Security#:		Policy #:	NYK 2972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 01/03/2001 Through: 02/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,163.32
Minus Other Benefits:	
Social Security Disability	$1,510.00 Calculated for entire period of 1 month
Dependent Social Security	$765.00 Calculated for entire period of 1 month
Net Benefit:	$1,888.32

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weil Medical College
Social Security#:		Policy #:	NYK 3972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 02/03/2001 Through: 03/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$755.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	**Policy Holder:**	**Weill Medical College**
Social Security#:		**Policy #:**	**NYK 1972**

General Information:

Basic %	70.0000%	**Maximum: $**	$15,000.00
Basic Monthly Earnings:	$5,933.32	**Minimum: $**	$100.00
Date of Disability:	06/06/2000	**Benefit Start Date:**	12/03/2000

Payment Period:

From: 03/03/2001 **Through:** 04/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$755.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weill Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 04/03/2001 Through: 05/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32
Minus Other Benefits:	
Social Security Disability	$1,510.00 Calculated for entire period of 1 month
Dependent Social Security	$755.00 Calculated for entire period of 1 month
Net Benefit:	$1,888.32

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weil Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	56,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 05/03/2001 Through: 06/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,610.00	Calculated for retro period of 1 month
Dependent Social Security	$755.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfono	**Policy Holder:**	**Weill Medical College**
Social Security#:		**Policy #:**	**NYK 1972**

General Information:

Basic %	70.000%	**Maximum: $**	$15,000.00
Basic Monthly Earnings:	$5,933.32	**Minimum: $**	$100.00
Date of Disability:	06/06/2000	**Benefit Start Date:**	12/03/2000

Payment Period:

From 06/03/2001 **Through:** 07/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$765.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	**Policy Holder:**	**Weill Medical College**
Social Security#:		**Policy #:**	**NYK 1972**

General Information:

Basic %	70.000%	**Maximum: $**	$15,000.00
Basic Monthly Earnings:	$5,933.32	**Minimum: $**	$100.00
Date of Disability:	06/06/2000	**Benefit Start Date:**	12/03/2000

Payment Period:

From: 07/03/2001 **Through:** 08/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32
Minus Other Benefits:	
Social Security Disability	$1,510.00 Calculated for entire period of 1 month
Dependent Social Security	$755.00 Calculated for entire period of 1 month
Net Benefit:	$1,888.32

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weil Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 08/03/2001 Through: 09/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$735.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Allano	Policy Holder:	Weil Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 09/03/2001 Through: 10/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32	
Minus Other Benefits:		
Social Security Disability	$1,510.00	Calculated for entire period of 1 month
Dependent Social Security	$755.00	Calculated for entire period of 1 month
Net Benefit:	$1,888.32	

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	**Policy Holder:**	**Weill Medical College**
Social Security#:		**Policy #:**	**NYK 1972**

General Information:

Basic %	70.000%	**Maximum: $**	$15,000.00
Basic Monthly Earnings:	$5,933.32	**Minimum: $**	$100.00
Date of Disability:	06/06/2000	**Benefit Start Date:**	12/03/2000

Payment Period:

From: 10/03/2001 **Through:** 11/02/2001 **1 month**

Payment Amount:

Gross Benefit:	$4,153.32
Minus Other Benefits:	
Social Security Disability	$1,510.00 Calculated for entire period of 1 month
Dependent Social Security	$755.00 Calculated for entire period of 1 month
Net Benefit:	$1,888.32

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: **$1,888.32**

Comments:

CIGNA
Group Insurance

Long Term Disability Benefit Statement

Direct Offset

Claimant Name:	Steven Alfano	Policy Holder:	Weill Medical College
Social Security#:		Policy #:	NYK 1972

General Information:

Basic %	70.000%	Maximum: $	$15,000.00
Basic Monthly Earnings:	$5,933.32	Minimum: $	$100.00
Date of Disability:	06/06/2000	Benefit Start Date:	12/03/2000

Payment Period:

From: 11/03/2001 Through: 12/02/2001 1 month

Payment Amount:

Gross Benefit:	$4,153.32
Minus Other Benefits:	
Social Security Disability	$1,510.00 Calculated for entire period of 1 month
Dependent Social Security	$755.00 Calculated for entire period of 1 month
Net Benefit:	$1,888.32

Taxes and Deductions:

FICA:	$0.00
Federal Income Tax:	$0.00
State Income Tax:	
Other Deductions:	

Amount you'll receive for this period: $1,888.32

Comments: